Children's Mental Health
Comprehensive Service Plan
- December 2007 -

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Name: _____

___Initial ___Annual
___Quarterly ___Discharge

Case Manager/ Transition Coordinator:_____

Meeting Date: / /

Plan Effective Dates: From / / To: / /

The People Who Participated in My Plan Development and Review

Person's name	Relationship	Attended Meeting	Agreement with my plan (Initial and Date)			
			Yes	No	Date	Comments

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Notice to Individuals, Family Members, Guardians and Advocates

I understand that if I have any questions, comments or concerns about my services. I can contact a program specialist at the Department of Medical assistance Services, 600 East Broad Street Suite 1300 Richmond, Virginia 23219. You can call (804) 225-4285.

PERSONAL PROFILE

For each profile domain, briefly describe the person's current situation, experiences and issues that will be addressed in the development of the individual plan. Please refer to the prompt questions in each section to assist in the completion of this section of the CSP.

I. Important Things to Know about Me

About Me	Response & Examples
Would I like to coordinate my own CSP?	
What are the most important things to know about me?	
How do I like to spend free time?	
What historical and other significant milestones do I want my CSP team members to know about me?	
What are my favorite things to do?	
Where are my favorite places to go?	
What are the parts of my heritage and ethnic background that are important for my CSP team to know?	▪ Family traditions ▪ Past events in my life that are important as to who I am today
Do I have a place of worship that is	

special to me?	
What is important in my routine?	

II. Accomplishments, Strengths and Things I am Most Proud of

About Me	Response & Examples
What are great things I have achieved over the last few years?	
What are my strengths and talents?	
What are my roles and responsibilities?	▪ At home? ▪ In my family? ▪ With friends? ▪ Work? ▪ Community?
What are the characteristics of the people who support me best?	

III. Important To/Important For

List the things that the CSP team needs to know concerning what is important to me including only what I am saying with my words and/or with my behavior. When my words and behavior are in conflict, please listen to my behavior.

List the things that are important for me, including only those things that I want people who support me to keep in mind regarding issues of health and safety and what others see as important to help me be a valued member of my community.

What is Important to Me	What is Important for Me

IV. Communication

These are the ways that I communicate: verbal, non-verbal and behaviorally (talking/shouting/yelling, avoidance, emotional release, aggression). This should be completed for all participants regardless of their communicative abilities).

When this is happening	I do this	We think it means	And this is what we should do

V. Home Life

About Me	Response & Examples
Where do I live with and with whom?	
Am I happy with my current living arrangement?	▪ Yes ▪ No, please explain. What would I like to change?
If I am living on my own	▪ How did I choose my home? ▪ How did I choose my neighborhood?
Do I feel safe in my home and neighborhood?	
Do I get be alone as much as I need?	▪ Yes: ▪ No (explain):
What are my responsibilities around the house?	
New Placement: What did you like best	

at a previous placement?	

VI. Work, Day or School

About Me	Response & Examples
How do I spend my day?	• School: • Work: • Other:
(For people who work) Do I make as much money as I would like?	
(For people who work) How many days per week do I work?	
Do I feel safe in my day environment?	
What are the things I would like to change about my day?	
What are the things I feel I do well during the day?	

VII. Relationships

List those relationships (important people) that are in my life.

Person	Relationship (friend, family, connection, significant other)	What they do for me (emotional support, transportation, help at the store, support me at work/home, etc)

VIII. My Health

Health Assessments	Date of Most Recent	Assessment Needed	N/A
Physical			
Dental			
Other Physician (list)			
OT/PT/Speech			
Physical Therapy			
Psychiatric			
Nutrition			
Substance Abuse (Drugs/Alcohol/Cigarettes)			

Health and Wellness Areas to Address May Include But are Not Limited to:

General Health, Neurological, Nutritional, Sensorimotor, Major chronic condition causing significant decline, Rapid decline in functional skills, Any other major health event in the past year, Newly diagnosed conditions, Behavioral/Mental Health, Substance Abuse Significant health risks (e.g., Seizures, Other significant risks)

Diagnosis/Conditions (List all diagnoses/ conditions based on most recent health assessments)	Current Treatment/Effectiveness (Include meds, treatment plans, etc.)	Possible Side Effects of Medications	Provider(s) & Date of last consult	Additional Supports Needed Including Assistance with Medication Administration
Primary (Axis I): Secondary (Axis II):				

Severity of Substance Abuse: Circle One: severe/moderate/mild/na				

IX. My Mental Health History

Mental Health History	Response
Age at first receipt of mental health services/support	
Number of PRTF admissions to date	
Date of first ever PRTF admission	
Date of admission at most recent PRTF stay	
Date of exit at most recent PRTF stay	
Date of first admission to the program services	

X. My Behavioral History

Behavioral History	Response
School absence severity:1= attend regularly 2= some attendance issues 3= problematic attendance issues 4= truant/refusing attendance	
Number of arrests in past 6 months	
Any involvement with law enforcement in the past 6 months	**Y or N**
Any probation in the past 6 months	**Y or N**
Any involvement with Child Protective Services in the past 6 months	**Y or N**
Harmful to self or others in the community	**Y or N**
Harmful to self or others in school setting	**Y or N**
Harmful to self or others in home setting	**Y or N**
Runaway in the past 3 months	**Y or N**
Has made a serious suicide attempt or is considered actively or possibly suicidal	**Y or N**

XI. Assessments I Have Had

Type of Assessment	Date of Most Recent	Needed	N/A
Risk Assessment (Suicidal/Harmful to self other/Aggression/Running Away)			
Assistive Technology			
Psychological (Diagnostic)			
Behavioral Functional Analysis			
Speech and Language/Communication			
Financial (Medicaid)			
Rights			
Critical Incident Review			
Educational			

XII. Independence

Topic	Status (Describe)		I Agree		The Team Agrees		Describe Any Action Needed In CSP
	Yes	No	Yes	No	Yes	No	
Guardianship Status							
Unsupervised Time							

Placement Appropriateness							
Grievance Procedure Received							

Topic	**Describe Level of Support**	**Rationale and Circumstances Leading Up To Needed Support**	**Plan for Restoring Independence**	**Review by Human Rights Committee**		**Individual/ Guardian Approval**	
				Yes/No	**Date**	**Yes/No**	**Date**
Financial Management				**Not applicable**		**Not applicable**	
Rights Restrictions							
Behavioral Supports [note: all restrictive behavioral interventions must have an associated CSP Goal]							

XIII. My Goals

What is my long term vision for my life?

About Me	Response & Examples From child/individual	Response & Examples from Parent/Guardian/Caregiver pertaining to child/individual interventions
Where do I see myself in the next few months/years?		
Where do I see myself living?		
How do I picture myself spending my days?	▪ Work ▪ School ▪ Friends ▪ Groups/Organizations ▪ Social	▪ Work ▪ School ▪ Friends ▪ Groups/Organizations ▪ Social
What are the things in my life I would like to remain the same?		
What are things in my life that I would like to see change?		
What are things in my life that I feel need to be figured out?		

XIV. Identified Supports

Support Area (including but not limited to the following areas)	**Supports Needed**	**Frequency**	**Person Responsible**	**Informal**	**Paid**	**Community**	**Status**
Home/Yard Maintenance (if living alone)							
Adaptive Equipment/Modifications							
Mobility							
Vision/Hearing							
Nutritional							
Communication							
Personal Finances							

Daily Living Activities:							
Health/Mental Health							
a. Appointments/Consults:							
b. Labs/Tests							
c. Other							
Other:							

XV. Action Plans

CSP Goal	Action Steps (include learning style, e.g., auditory, visual, hands on)	Person Responsible	Paid	Informal	Generic	Frequency of Support (e.g., # of days per week)	Start Date	Target Date for Completion

Frequency of Monitoring Goal and Action Steps	By Whom?	How will they be monitored?	Comments about monitoring

Progress in Meeting Goal

Data		Met	Progress	No Progress	Status	Date of Review
Source	**N/A**					
What was learned about me during this review period? **(Child/Individual/Family/Caregiver/Professional Point of views)**						

Action Plans

CSP Goal	Action Steps (include learning style, e.g., auditory, visual, hands on)	Person Responsible	Paid	Informal	Generic	Frequency of Support (e.g., # of days per week)	Start Date	Target Date for Completion

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Source	N/A				
What was learned about me during this review period? (Child/Individual/Family/Caregiver/Professional Point of views)					

Action Plans

CSP Goal	Action Steps (include learning style, e.g., auditory, visual, hands on)	Person Responsible	Paid	Informal	Generic	Frequency of Support (e.g., # of days per week)	Start Date	Target Date for Completion
Frequency of Monitoring Goal and Action Steps	**By Whom?**	**How will they be monitored?**	**Comments about monitoring**					

Progress in Meeting Goal

Data		Met	Progress	No Progress	Status
Source	**N/A**				
What was learned about me during this review period? **(Child/Individual/Family/Caregiver/Professional Point of views)**					

XVI. Summary of Supports and Services
Includes paid and informal supports

NON-WAIVER SERVICES			
Service Type	**Service/Supports**	**Provider Name**	**Amount/Frequency**
Case Management			
School			
Medical			
Mental Health			
OT/PT/SLP Therapy			
OTHER			

XVII. Provider Emergency Back-Up Support

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This must be completed for individuals who receive waiver supports less than 24 hours per day. The plan shall be individualized and shall outline how supports will be assured in the absence of scheduled staff or in the event of emergency that may require an increase in supports. This plan must be agreed upon by all team members.

☐ An Individualized Back-Up Support Plan is not required
☐ An Individualized Back-Up Support Plan is required and attached
An Individualized Back-Up Support Plan is required but not attached: why:_____

Type of Supervision Support Provided	**Name of Emergency Contact Person**	**Telephone number of Emergency Contact Person**	**Specify Protocol (Give specific step by step instructions)**

Department of Medical Assistance Services

Children's Mental Health Program

☐ Initial Plan ☐ Renewal ☐ Revision ☐ Termination ☐ Interruption

Individual's Name: _____ _____ _____

LAST **FIRST** **M.**

Medicaid Number: _____

Birthrate mo/dy/year) _____ Social Security No: _____

Transition Coordinator/ Case Manager: _____

Provider API/NPI#: _____ Phone: _____ Fax:

Service	Cost Per Unit/Hour	Amount X Frequency	Number of units/Hrs Needed for Year	Total Service Cost	DMAS Changes
Companion Care	$14.76 NOVA $12.53 ROS				
CD-Companion Care	$11.14 NOVA $8.60 ROS				
CD-Respite	$11.14 NOVA $8.60 ROS				
Respite Care Always per calendar year	$14.76 NOVA $12.53 ROS				
Environmental Modification Multiple requests cannot exceed $5000 per CSP year	Limit $5000. Per calendar year				
Family Caregiver Training	$53.89 NOVA $46.86 ROS				
In-Home Residential Support	$22.82 NOVA $19.85 ROS				
Transition Coordination (Max of 160 units)	$16.50 per unit				

Individual's Name_____ Medicaid #_____

Service	Cost Per Unit/Hour	Amount X Frequency	Number of units/Hrs Needed for Year	Total Service Cost	DMAS Changes
Therapeutic Consultation					
Behavioral Consultation	$63.40 NOVA $55.13 ROS				
Occupational Therapy	$63.40 NOVA $55.13 ROS				
Psychology	$63.40 NOVA $55.13 ROS				
Rehabilitation Engineering	$63.40 NOVA $55.13 ROS				
Speech and Language Pathology	$63.40 NOVA $55.13 ROS				
Therapeutic Recreation	$63.40 NOVA $55.13 ROS				
Total Service Cost	XXXXXXXXXXXXX				

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

Individual/Guardian Signature

Date

Case Manager Signature

Date